Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INNOVA HOSPITAL SAN ANTONIO
4243 E SOUTHCROSS BLVD
SAN ANTONIO TX 78222-3727

Respondent Name
Liberty Mutual Fire Insurance

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-0365-01

MFDR Date Received
September 27, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that you will find he did perform the authorized procedures."

Amount in Dispute: $1672.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Liberty Mutual believes that Innova Hospital San Antonio has been appropriately reimbursed for services rendered…"

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2010	Outpatient Hospital Services	$1,672.02	$1,672.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 9, 2010
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE.
   - X094 – CHARGES INCLUDED IN THE FACILITY FEE.
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.

- X263 – THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE.
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- U693 – BY CLINICAL PRACTICE STANDARDS. THIS PROCEDURE IS INCIDENTAL TO THE RELATED PRIMARY PROCEDURE BILLED.
- B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED.

Explanation of benefits July 12, 2010

- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE.
- X094 – CHARGES INCLUDED IN THE FACILITY FEE.
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
- X263 – THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE.
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- U693 – BY CLINICAL PRACTICE STANDARDS. THIS PROCEDURE IS INCIDENTAL TO THE RELATED PRIMARY PROCEDURE BILLED.
- B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED.

Explanation of benefits dated September 14, 2010

- U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES.
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE.
- B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED.
- X094 – CHARGES INCLUDED IN THE FACILITY FEE.
- X263 – THE CODE BILLED DOES NOT MEET THE LEVEE/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE.
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- U693 – BY CLINICAL PRACTICE STANDARDS. THIS PROCEDURE IS INCIDENTAL TO THE RELATED PRIMARY PROCEDURE BILLED.
- X070 – LETTER TO FOLLOW.
- X133 – THIS CHARGE WAS NOT REFLECTED IN THE REPORT AS ONE OF THE PROCEDURES OR SERVICES PERFORMED.
- X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE.

Issues

1. Are disputed services supported by medical documentation?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied disputed service with reason code, X263 – "THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE." Review of the submitted documentation shows the requestor submitted a medical bill with procedure code 29888, "Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction." The requestor also submitted "Operative Report" identifying procedures performed. Review of report shows repair of anterior cruciate ligament was performed. Specifically;

a. Page 4, item number 6, "…relieving impingement on the anterior cruciate ligament during flexion/extension of the knee joint."

Therefore, the Division concludes that the denial code is not supported. The disputed services will therefore be reviewed per applicable Division rules and guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code S9430 is not a valid code or was not in effect on the date the services were provided. 28 Texas Administrative Code §134.403(d) requires that, for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rule. Medicare payment policies require the accurate reporting of medical services using valid Healthcare Common Procedure Coding System (HCPCS) codes. Review of the submitted documentation finds that the procedure code reported is not recognized by Medicare as a valid HCPCS code for the date the services were rendered. This service does not meet the requirements of §134.403(d). Reimbursement cannot be recommended.
- Procedure code S5000 is not a valid code or was not in effect on the date the services were provided. 28 Texas Administrative Code §134.403(d) requires that, for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rule. Medicare payment policies require the accurate reporting of medical services using valid Healthcare Common Procedure Coding System (HCPCS) codes. Review of the submitted documentation finds that the procedure code reported is not recognized by Medicare as a valid HCPCS code for the date the services were rendered. This service does not meet the requirements of §134.403(d). Reimbursement cannot be recommended.
- Per Medicare policy, procedure code J8499 may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code A4649 is not a valid code or was not in effect on the date the services were provided. 28 Texas Administrative Code §134.403(d) requires that, for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rule. Medicare payment policies require the accurate reporting of medical services using valid Healthcare Common Procedure Coding System (HCPCS) codes. Review of the submitted documentation finds that the procedure code reported is not recognized by Medicare as a valid HCPCS code for the date the services were rendered. This service does not meet the requirements of §134.403(d). Reimbursement cannot be recommended.
- Procedure code 99070 has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.12. 125% of this amount is $15.15
- Procedure code 82947 is unbundled. This procedure is a component service of procedure code 80048

performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.

- Procedure code 82310 is unbundled. This procedure is a component service of procedure code 80048 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 82435 is unbundled. This procedure is a component service of procedure code 80048 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 82565 is unbundled. This procedure is a component service of procedure code 80048 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 82962 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.35. This amount multiplied by 2 units is $6.70. 125% of this amount is $8.37
- Procedure code 84132 is unbundled. This procedure is a component service of procedure code 80048 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 84520 is unbundled. This procedure is a component service of procedure code 80048 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.39. This amount multiplied by 2 units is $6.78. 125% of this amount is $8.48
- Procedure code 85018 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.39. This amount multiplied by 2 units is $6.78. 125% of this amount is $8.48
- Procedure code 29888 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0052, which, per OPPS Addendum A, has a payment rate of $5,961.06. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,576.64. This amount multiplied by the annual wage index for this facility of 0.8913 yields an adjusted labor-related amount of $3,187.86. The non-labor related portion is 40% of the APC rate or $2,384.42. The sum of the labor and non-labor related amounts is $5,572.28. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2010 Default CCR as 0.2223. This ratio multiplied by the billed charge of $8,575.00 yields a cost of $1,906.22. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $5,572.28 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $4,451.74. The allocated portion of packaged costs is $4,451.74. This amount added to the service cost yields a total cost of $6,357.96. The cost of these services exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $5,572.28. This amount multiplied by 200% yields a MAR of

$11,144.56.

- Procedure code 1400 is included in the global surgical package. This service is considered an integral part of another surgical procedure, and payment is included in the payment for the primary surgery is performed within the global period. Separate payment is not recommended.
- Per Medicare policy, procedure code 94660 may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

4. The total allowable reimbursement for the services in dispute is $11,185.04. The amount previously paid by the insurance carrier is $218.72. The requestor is seeking additional reimbursement in the amount of $1,672.02. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,672.02.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,672.02, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 14, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.